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FLEXIBLE SPENDING ACCOUNT (FSA) PLAN

INTRODUCTION

The purpose of this Plan is to furnish Employees of the Employer with a choice of receiving certain tax free benefits provided by the Employer in lieu of taxable compensation. It is the intention of the Employer that the Plan qualify as a "cafeteria plan" within the meaning of Section 125(d) of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be eligible for exclusion from such Employee's gross income under Section 125(a) of the Internal Revenue Code of 1986, as amended, and other applicable Sections of the Internal Revenue Code, as amended.

GENERAL PROVISIONS

1. DEFINITIONS

Account or Accounts means a Participant's reimbursement account maintained by the Employer under any plan described herein, unless the context clearly indicates otherwise.

Benefit shall mean any Qualified Benefit provided to a Participant under Section 3A.

Code shall mean the Internal Revenue Code of 1986, as amended.

Compensation shall mean the entire amount paid to an Employee during the Plan Year as salary, wages, commissions, overtime pay and bonuses, but excluding earnings prior to entering the Plan and benefits and credits under this or any other employee benefit plan of the Employer.

Effective Date of this amended and restated Plan shall be July 1, 1997. The original effective date of this Plan is January 1, 1992.

Employee shall mean an employee of the Employer who is a participant in any Employee Benefit Plan that requires him to make a contribution for the benefits provided thereunder.

Employee Benefit Plan shall mean programs sponsored by the Employer which are eligible for inclusion in a cafeteria plan under Code Section 125 and which are described in Section 3A of this Plan.

Employer shall mean the STATE OF IDAHO and any agency or political subdivision thereof authorized by the Employer to adopt and participate in this Plan.

Highly Compensated Participant shall mean any employee defined in Code Section 125(e).

Key Employee shall mean any employee defined in Code Section 416(i)(1).

Participant shall mean any Employee who is qualified to participate in this Plan and is participating in this Plan.

Plan shall mean the cafeteria plan of the Employer established pursuant to Code Section 125 as set forth in and by this document and all subsequent amendments thereto, unless the context clearly indicates otherwise.

Plan Administrator shall be the Employer or any other person or company appointed by the Employer.

Plan Name shall be STATE OF IDAHO SECTION 125 PLAN.

Plan Year shall mean the twelve (12) consecutive month period from July 1 to June 30.

Qualified Benefit shall mean any benefit which is not includible in the gross income of the Employee by reason of an express provision of Chapter 1 of Subtitle A of the Code (other than Code Sections 117, 124, 127 or 132) and which is offered as a Benefit under this Plan.

2. ELIGIBILITY AND PARTICIPATION

A. An Employee of the Employer shall be eligible to participate in the premium conversion portion of this Plan on the date he first becomes a participant in any Employee Benefit Plan that requires him to make contributions for the benefits provided thereunder. Any Employee of the Employer shall be eligible to participate in all other Qualified Benefits in this Plan on the July 1 coinciding with or next following the date the Employee completes ten months of continuous employment with the Employer.

B. Notwithstanding anything in this Plan to the contrary, if a Participant ceases to be an Employee, or an Employee eligible to participate in this Plan, his participation in this Plan shall terminate on the date such Participant ceases to be an Employee or ceases to be eligible to participate in this Plan, whichever occurs first; provided, however, that the former Participant may continue to receive payment of Benefits to the extent funds are available from his Compensation reduced for expenses incurred prior to the date he ceased being a Participant. No Benefits under this Plan will be provided or paid to any Employee for expenses incurred after the date he ceases to be a Participant in the Plan unless such Employee properly elects applicable coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) and pays the required premiums, and then only to the extent permitted by COBRA.

C. Subject to Section 3H, any Participant who ceases to be (a) an Employee, or (b) an Employee eligible to participate in this Plan, shall again participate in this Plan on the date of his re-employment by the Employer (if he then meets the eligibility requirements) or upon his satisfaction of the eligibility requirements, as the case may be.

D. Participation in this Plan shall be voluntary on the part of each eligible Employee. Unless an eligible Employee elects not to participate in writing, the Employee shall be deemed to be a Participant in this Plan.

E. Each Employee who elects to participate in this Plan agrees to have his Compensation reduced by the cost of the Benefit selected under the Plan.

3. BENEFITS

A. Each Participant shall, subject to a uniform, nondiscriminatory procedure established by the Plan Administrator, elect either Choice A, to receive his full Compensation for the Plan Year, or Choice B, to receive his Compensation for the Plan Year reduced by the cost of the Benefits selected, and to have such reduction applied by the Employer toward the cost of one or more of the following Qualified Benefits:

1. Dependent Care Assistance Plan;
2. Group Health Insurance Plan; or
3. Medical Reimbursement Plan.

A Participant shall not reduce his Compensation in any Plan Year more than the amount shown on page 11 for the Dependent Care Assistance Plan and for the Medical Reimbursement Plan.

The maximum percentage of Compensation that may be contributed by an Employee as elective contributions to this Plan is one hundred (100%) percent of such Employee's Compensation.

Amounts contributed for one plan shall not be used for payment of benefits under another plan.

B. The Plan Administrator may, upon prior notice to the Participants, charge a Participant's Account a reasonable administrative charge on a non-discriminatory basis.

C. The Benefits under the plans available under Section 3A, the requirements for participating in such plans, and the other terms and conditions of coverage under said plans are as set forth from time to time in said plans. The Benefit description in each of said plans, as in effect from time to time, is hereby made a part hereof and incorporated by reference into this Plan. Notwithstanding the foregoing, if any unused amount remains in a Participant's Account at the end of a Plan Year, such amount shall be forfeited by the Participant after the ninetieth (90th) day following the end of the Plan Year. No distribution shall be made from any such Account to the Participant or his beneficiary nor shall a Participant or his beneficiary receive such unused amounts in the form of other Benefits.

D. The Plan Administrator shall provide a written election and enrollment form to each Employee eligible to participate in this Plan. Each eligible Employee shall make an election pursuant to Section 3A for a Plan Year. Each election and enrollment form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be before the first day of the pay period for which the Participant's election will apply.

E. A Participant failing to return a completed election and enrollment form to the Plan Administrator on or before the specified due date shall be deemed to have reelected the same premium conversion choice he made on his last filed election and enrollment form; provided, however, if such Participant has never completed an election and enrollment form, such Participant is deemed to have elected Choice A in this Plan. A Participant failing to return a completed election and enrollment form to the Plan Administrator on or before the specified due date shall be deemed to have elected Choice A in this Plan with respect to all other Qualified Benefits in this Plan.

F. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirements imposed by the Code, or any limitation on benefits imposed upon Highly Compensated Participants or Key Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under

rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Participants or Key Employees with or without the consent of such Participants.

G. Elections made under the Plan (or deemed to be made under Section 3E shall be irrevocable by the Participant during the Plan Year, subject to a change in family status, a cost change, or a coverage change.

(1) A Participant may revoke a Benefit election for the balance of a Plan Year and file a new election if both the revocation and the new election are on account of and consistent with a change in family status. A change in family status for this purpose includes marriage, divorce, death of a spouse or dependent, birth or adoption of a child of the Employee or termination of employment (or commencement of employment) of a Participant's spouse, the switching from part-time to full-time status by an Employee or the Employee's spouse and the taking of an unpaid leave of absence by the Employee or the Employee's spouse, and such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service. Any new election under this Section shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator.

(2) If the cost of a health plan provided by an independent, third party provider under the Plan increases or decreases during a Plan Year, then the Plan Administrator shall automatically increase or decrease, as the case may be, all affected Participants' elections for such health plan. If the premium amount significantly increases, the Plan Administrator, on a reasonable and consistent basis, may permit Participants either to make a corresponding change in their elections or to revoke their elections and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

(3) If coverage under a health plan provided by an independent, third party provider is significantly curtailed or ceases during a period of coverage, the Plan Administrator may permit all affected Participants to revoke their elections in the health plan and, in lieu thereof, to receive on a prospective basis coverage under another health plan with similar coverage.

Notwithstanding the foregoing, if there is a change in family status, a cost change, or a coverage change, a Participant may increase or decrease his Group Health Insurance Premium, but may only increase (and not decrease) his contribution to the Medical Reimbursement Plan or the Dependent Care Assistance Plan.

H. Except as provided under Code Sections 162(k) and 4980B (relating to COBRA), elections made under this Plan (or deemed to be made under Section 3E shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or Benefits under the plans available under Section 3A may continue if and to the extent provided by such plans. If a Participant terminates employment with the Employer and revokes (or is deemed to revoke) existing benefit elections and terminates (or is deemed to terminate) the receipt of benefits, and such Participant returns to work for the Employer during the Plan Year in which he terminated employment, such Participant shall not make any new benefit elections for the remaining portion of the Plan Year.

4. ADMINISTRATION OF PLAN

A. The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator shall have full power and discretion to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers and discretion will include, but will not be limited to, the following authority, in addition to all other powers and discretion provided by this Plan:

(1) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(2) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming Benefits under the Plan;

(3) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(4) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(5) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under the plans available under Section 3A shall not be subject to review under this Plan, and the Plan Administrator's authority under this Section A. shall not extend to any matter as to which an administrator under any such other plan is empowered to make.

B. The Plan Administrator will make available to each Participant such Participant's records under the Plan as pertain to such Participant for examination at reasonable times during normal business hours.

C. In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of the administrators of the plans available under Section 3A or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

D. Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

E. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, provided such act or omission is in good faith.

F. No actual funds or assets shall be maintained under this Plan. However, the Plan Administrator shall maintain a record of a Participant's coverage amount and salary reduction and expenditures thereof pursuant to such practices and procedures as it may adopt.

5. AMENDMENT AND TERMINATION OF PLAN

A. This Plan is established by the Employer with the intention of being maintained for an indefinite period of time. This Plan shall be subject to amendment or termination at any time hereafter by the Employer. Any amendment or action to terminate this Plan shall be in writing and shall be executed by an official of the Employer. Subject to Section 3C, upon termination of the Plan, any coverage amounts not used on behalf of the Participant shall, if feasible, be used to continue coverage for the Benefits in which the Participant is enrolled.

6. MISCELLANEOUS PROVISIONS

A. This Plan shall be maintained for the exclusive benefit of the Employer's Employees.

B. Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

C. Under no circumstances shall this Plan permit the deferral of the receipt of any Compensation by a Participant.

D. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any Benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Plan Administrator, except as provided herein. Notwithstanding the preceding sentence, a Participant's rights under this Plan are legally enforceable.

E. Nothing contained in this Plan shall be construed to constitute a contract of employment between the Employer and any Employee, or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

F. The Plan is not intended to be and is not in lieu of any workers' compensation act insurance and does not affect any requirement for worker's compensation act insurance coverage.

G. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and the Plan shall be construed and enforced as if such provisions had not been included.

H. No Employee, Participant, dependent or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the Benefits payable under the Plan to such Employee, Participant, dependent or beneficiary.

I. Except as otherwise provided in each of the plans providing Benefits, amounts payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, pledge, encumbrance, assignment, charge, garnishment, levy, or execution. The Employer shall not be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts or any person entitled to Benefits hereunder.

J. For purposes of this Plan, use of the masculine gender shall include the feminine gender and use of the singular shall include the plural, unless the context clearly indicates otherwise.

K. Except as preempted by Federal law, this Plan shall be construed, administered and enforced according to the laws of the State of Idaho.

7. CLAIMS PROCEDURE

A. Any Employee, beneficiary, or his duly authorized representative may file a claim for a Plan benefit to which the claimant believes that he is entitled, but has been previously denied by the Plan Administrator. Such a claim must be in writing and delivered to the Plan Administrator in person or by mail, postage paid. Within ninety (90) days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed ninety (90) days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial ninety (90) day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with this Section 7A, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to review pursuant to Sections 7C and 7D.

B. The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written notice setting forth in a manner calculated to be understood by the claimant, containing the following information:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(4) An explanation of the Plan's claim review procedure.

C. Within sixty (60) days after the receipt by the claimant of written notification of the denial (in whole or in part) of his claim, the claimant or his duly authorized representative (a) may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a review of such denial; (b) may review pertinent documents; and (c) may submit issues and comments in writing.

D. Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with this Section 7D, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to legal remedy pursuant to Section 7E.

E. After exhaustion of the claims procedure is provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy.

8. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A. The Plan Administrator shall adhere to the terms of any qualified medical support order that satisfies the requirements of this Section 8 and Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). For purposes of this Section, a qualified medical support order is a medical child support order which creates or recognizes the existence of an alternate recipients right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under a group health plan. A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) which (1) relates to the provision of child support with respect to a child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan, or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan,if such judgment, decree, or order (a) is issued by a court of competent jurisdiction or (b) is issued through an administrative process established under state law and has the force and effect of law under applicable state law. For purposes of this Section, an "alternate recipient" shall mean any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

B. Any such medical child support order must clearly specify the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, a reasonable description of the type of coverage to be provided under the group health plan to each such alternate recipient, or the manner in which such type of coverage is to be determined, the period to which such order applies, and each plan to which such order applies.

C. Any such medical child support order shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

D. The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If a Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

E. Alternate recipients of a qualified medical child support order shall be treated a beneficiary under the Plan for all purposes of ERISA.

F. Payments under this Plan under a medical child support order described in this Section in reimbursement for expenses paid by the alternate recipient or the alternate recipients custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipients custodial parent or legal guardian.

Dependent Care Account

Plan Year	Reimbursement Amount
July 1, 1997 – June 30, 1998	$5,000

Medical Reimbursement Account

Plan Year	Reimbursement Amount
July 1, 1997 – June 30, 1998	$1,300

MEDICAL REIMBURSEMENT PLAN FOR THE STATE OF IDAHO

The State of Idaho, hereinafter referred to as "Employer", hereby adopts this Medical Reimbursement Plan, hereinafter referred to as the "Plan", for the benefit of its employees in coordination with the State of Idaho Section 125 Plan, herein referred to as "Section 125 Plan".

9. REIMBURSEMENT FOR MEDICAL CARE EXPENSES.

A. As limited hereinbelow, effective July 1, 1997, the Employer, or its agent, will reimburse a Participant each calendar month during a Plan Year, or at such other times as the Employer may elect (if more frequent), for expenses incurred by such Participant for medical care, as defined in Section 213 of the Internal Revenue Code, as amended ("Code"), of such Participant, his spouse, and his dependents, as defined in Section 152 of the Code.

B. The reimbursement to, or the payment on behalf of, any one Participant, including his spouse and his dependents, shall not exceed in any Plan Year the amount shown on page I-16, and shall be limited in a Plan Year to the amount which the Participant has designated and contributed into his Medical Reimbursement Account in the Section 125 Plan, reduced by any previous amounts paid from such Account pursuant to this Plan for medical care expenses incurred during such Plan Year. No reimbursement of expenses incurred in a Plan Year shall be paid from amounts contributed and designated to another Plan Year.

C. Any Participant applying for reimbursement under this Plan shall submit to the Employer, or its agent, a written statement from an independent third party stating the amount of the expense incurred. The Participant must also provide a written statement that the expense is not reimbursable under any other plan. The Participant shall maintain hospitalization, doctor, disability, dental or other medical bills for verification by the Employer if the Employer, or its agent, requests such bills prior to reimbursement. A failure to comply herewith may, at the discretion of the Employer, terminate such Participant's right to said reimbursement.

D. In any one Plan Year, the Employer shall not reimburse, or be liable in any manner for any medical care expense of a Participant in excess of the amount shown on page I-16, and for which the Participant did not allocate funds to his Medical Reimbursement Account under the Section 125 Plan.

E. Subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a Participant who terminates employment shall only be entitled to reimbursement of medical care expenses incurred while a Participant.

F. A Participant must file a claim for reimbursement under his Medical Reimbursement Account no later than ninety (90) days following the end of the Plan Year. If any unused amount remains in a Participant's Medical Reimbursement Account at the end of a Plan Year for which a claim is not timely filed, such amount shall be forfeited by the Participant on the ninety-first (91st) day following the end of the Plan Year.

10. OTHER INSURANCE

Reimbursement under this Plan shall be made by the Employer only in the event and to the extent that such reimbursement or payment is not provided for under any insurance policy or policies, whether owned by the Employer or the Participant, or the Participant's spouse, or dependent, or under any other health and accident or wage continuation plan. In the event that there is such a policy or plan in effect providing for reimbursement or payment in whole or in part, then to the extent of the coverage under such policy or plan, the Employer shall not pay any such claim. A Participant shall not file a claim if the claim is covered by insurance. The Participant shall be responsible for notifying the Employer that a prior paid claim is covered by insurance.

11. PURPOSE

The Employer intends to operate this Plan so that benefits payable under this Plan shall qualify for exclusion from the gross income of the Participants covered by this Plan, as provided by Sections 105 and 106 of the Code. This Plan is operated solely in coordination with the Section 125 Plan (which is incorporated herein and made a part hereof by reference) and shall be construed and interpreted accordingly.

12. PARTICIPANT

A Participant is an employee of the Employer who is participating in the Section 125 Plan. Any employee who is either not eligible to participate in the Section 125 Plan, or who is not participating in the Section 125 Plan, shall not participate in this Plan.

13. PLAN YEAR

For purposes of this Plan, the Plan Year is defined to mean the twelve (12) month period from July 1 to June 30.

14. PLAN ADMINISTRATOR

The Plan Administrator shall be the Employer or any other person or company appointed by the Employer.

15. CLAIMS PROCEDURE

A Participant or beneficiary shall have the right to file a claim, inquire if he or she has any right to benefits and the amounts thereof, or appeal the denial of a claim.

A claim will be considered as having been filed when an authorized claim form is filed with the Employer, or its agent, by the Participant or his authorized representative. The claim request shall be brought to the attention of the Plan Administrator.

The Plan Administrator shall notify the claimant in writing within ninety (90) days after receipt of the claim if the claim is wholly or partially denied. If an extension of time beyond the initial ninety (90) day period for processing the claim is required, written notice of the extension shall be provided to the claimant prior to the termination of the initial ninety (90) day period. In no event shall the extension exceed a period of ninety (90) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a final decision.

Notice of a wholly or partially denied claim for benefits will be in writing in a manner calculated to be understood by the claimant and shall include:

A. The reason or reasons for denial;

B. Specific reference to the Plan provisions that apply;

C. A description of any additional material or information that would be helpful to the Plan Administrator in further review of the claim, and reasons why it is necessary; and

D. An explanation of the Plan's claim appeal procedure.If a claim is denied, the claimant may file an appeal asking the Plan Administrator to conduct a full and fair review of his claim. An appeal must be made in writing no more than sixty (60) days after the claimant receives written notice of the denial. The claimant may review any documents that apply to the case and may also submit points of disagreement and other comments in writing along with the appeal.

The decision of the Plan Administrator regarding the appeal shall be given to the claimant in writing no later than sixty (60) days following receipt of the appeal. However, if a hearing is held, or there are special circumstances involved, the decision will be given no later than one hundred twenty (120) days after receiving the appeal. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The decision shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent Plan provisions on which the decision is based.

16. ALIENATION OF BENEFITS

No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a qualified medical child support order pursuant to Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA") and Paragraph 17 on page 14.

17. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan Administrator shall adhere to the terms of any qualified medical support order that satisfies the requirements of this Paragraph 17 and Section 609 of ERISA. For purposes of this Paragraph, a qualified medical support order is a medical child support order which creates or recognizes the existence of an alternate recipients right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under a group health plan. A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) which

A. relates to the provision of child support with respect to a child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan, or

B. enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan,if such judgment, decree, or order (a) is issued by a court of competent jurisdiction or (b) is issued through an administrative process established under state law and has the force and effect of law under applicable state law. For purposes of this Paragraph, an "alternate recipient" shall mean any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

Any such medical child support order must clearly specify the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, a reasonable description of the type of coverage to be provided under the group health plan to each such alternate recipient, or the manner in which such type of coverage is to be determined, the period to which such other applies, and each plan to which such order applies.

Any such medical child support shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If a Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

An alternate recipient of a qualified medical child support order shall be treated as a beneficiary under the Plan for all purposes of ERISA.

Payments under this Plan under a medical child support order described in this Paragraph in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

18. APPLICABLE LAW

The Plan shall be construed and enforced according to the laws of the State of Idaho to the extent not preempted by any federal law.

19. AMENDMENT AND TERMINATION

This Plan shall be subject to amendment or termination at any time hereafter by the Employer; provided, however, that such amendment or termination shall not affect any right to claim reimbursement for medical expenses under the provisions of Paragraph 9A arising prior to said amendment or termination. Any amendment or action to terminate this Plan shall be in writing and shall be executed by an official of the Employer.

Plan Year	Reimbursement Amount
July 1, 1997 – June 30, 1998	$1,300

DEPENDENT CARE ASSISTANCE PLAN FOR THE STATE OF IDAHO

The State of Idaho, hereinafter referred to as "Employer", hereby adopts this Dependent Care Assistance Plan, hereinafter referred to as the "Plan", for the benefit of its employees in coordination with the State of Idaho Section 125 Plan, herein referred to as "Section 125 Plan".

20. REIMBURSEMENT FOR DEPENDENT CARE ASSISTANCE

A. As limited hereinbelow, effective July 1, 1997, the Employer, or its agent, will reimburse a Participant each calendar month during a Plan Year, or at such other times as the Employer may elect (if more frequent), for employment-related expenses, as defined in Section 21(b)(2) of the Internal Revenue Code of 1986, as amended ("Code"), incurred by such Participant for household services or for the care of a qualifying individual, but only if the expenses are necessary for the gainful employment of the Participant.

B. The amount of dependent care assistance that a Participant is entitled to exclude from income for any taxable year cannot exceed: (1) in the case of a Participant who is not married at the close of the taxable year, the Participant's earned income for the taxable year; (2) in the case of a Participant who is married at the close of the taxable year, the lesser of the earned income of the Participant for the taxable year or the earned income of the spouse of the Participant for the taxable year.

"Earned income" means earned income as defined in Code Section 32(c)(2), but does not include any amounts paid or incurred by an employer for dependent care assistance to a Participant. For purposes of 20B, the provisions of Section 21(d)(2) of the Code shall apply in determining the earned income of a spouse who is a student or incapable of caring for himself.

C. Notwithstanding 20B, the reimbursement to, or the payment on behalf of, any one Participant, including his spouse and his dependents, in any one Plan Year shall not exceed the amount shown in paragraph 19 (one-half (1/2) of the designated amount in the case of a separate return by a married Participant) and shall be limited in a Plan Year to the amount which the Participant has designated and contributed into his Dependent Care Assistance Account in the Section 125 Plan, reduced by any previous amounts paid from such Account pursuant to this Plan for dependent care assistance expenses incurred during such Plan Year. No reimbursement of expenses incurred in a Plan Year shall be paid from amounts contributed and designated to another Plan Year.

D. Any Participant applying for reimbursement under this Plan shall submit to the Employer, or its agent, a written statement from an independent third party stating the amount of the expense incurred. The Participant must also provide a written statement that the expense is not reimbursable under any other plan. The Participant shall maintain dependent care assistance bills for verification by the Employer if the Employer, or its agent, requests such bills prior to reimbursement. A failure to comply herewith may, at the discretion of the Employer, terminate such Participant's right to said reimbursement.

E. In any one Plan Year the Employer shall not reimburse, or be liable in any manner for any dependent care assistance expense of a Participant in excess of the amount shown on page 18 (one-half (1/2) of the designated amount in the case of a separate return by a married Participant) and for which the Participant did not allocate funds to his Dependent Care Assistance Account under the Section 125 Plan.

F. A Participant who terminates employment shall only be entitled to reimbursement of dependent care assistance expenses incurred while a Participant.

G. A Participant must file a claim for reimbursement under his Dependent Care Assistance Account no later than ninety (90) days following the end of the Plan Year. If any unused amount remains in a Participant's Dependent Care Assistance Account at the end of a Plan Year for which a claim is not timely filed, such amount shall be forfeited by the Participant on the ninety-first (91st) day following the end of the Plan Year.

21. PURPOSE

The Employer intends to operate this Plan so that benefits payable under this Plan shall qualify for exclusion from the gross income of the Participants covered by this Plan, as provided by Section 129 of the Code. This Plan is operated solely in coordination with the Section 125 Plan (which is incorporated herein and made a part hereof by reference) and shall be construed and interpreted accordingly.

22. PARTICIPANT

A Participant is an employee of the Employer who is participating in the Section 125 Plan. Any employee who is either not eligible to participate in the Section 125 Plan, or who is not participating in the Section 125 Plan, shall not participate in this Plan.

23. PLAN YEAR

For purposes of this Plan, the Plan Year is defined to mean the twelve (12) month period from July 1 to June 30.

24. PLAN ADMINISTRATOR

The Plan Administrator shall be the Employer or any other person or company appointed by the Employer.

25. CLAIMS PROCEDURE

A Participant or beneficiary shall have the right to file a claim, inquire if he or she has any right to benefits and the amounts thereof, or appeal the denial of a claim.

A claim will be considered as having been filed when an authorized claim form is filed with the Employer, or its agent, by the Participant or his authorized representative. The claim request shall be brought to the attention of the Plan Administrator.

The Plan Administrator shall notify the claimant in writing within ninety (90) days after receipt of the claim if the claim is wholly or partially denied. If an extension of time beyond the initial ninety (90) day period for processing the claim is required, written notice of the extension shall be provided to the claimant prior to the termination of the initial ninety (90) day period. In no event shall the extension exceed a period of ninety (90) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a final decision.

Notice of a wholly or partially denied claim for benefits will be in writing in a manner calculated to be understood by the claimant and shall include:

A. The reason or reasons for denial;

B. Specific reference to the Plan provisions that apply;

C. A description of any additional material or information that would be helpful to the Plan Administrator in further review of the claim, and reasons why it is necessary; and

D. An explanation of the Plan's claim appeal procedure.If a claim is denied, the claimant may file an appeal asking the Plan Administrator to conduct a full and fair review of his claim. An appeal must be made in writing no more than sixty (60) days after the claimant receives written notice of the denial. The claimant may review any documents that apply to the case and may also submit points of disagreement and other comments in writing along with the appeal.

The decision of the Plan Administrator regarding the appeal shall be given to the claimant in writing no later than sixty (60) days following receipt of the appeal. However, if a hearing is held, or there are special circumstances involved, the decision will be given no later than one hundred twenty (120) days after receiving the appeal. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The decision shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent Plan provisions on which the decision is based.

26. STATEMENT

The Plan Administrator shall furnish to each Participant on or before January 31 following a Plan Year, a written statement showing the amounts paid by the Plan in providing dependent care assistance to such Participant during the previous Plan Year.

27. AMENDMENT AND TERMINATION

This Plan shall be subject to amendment or termination at any time hereafter by the Employer; provided, however, that such amendment or termination shall not affect any right to claim reimbursement for dependent care expenses under the provisions of Paragraph 20A arising prior to said amendment or termination. Any amendment or action to terminate this Plan shall be in writing and shall be executed by an official of the Employer.

28. APPLICABLE LAW

The Plan shall be construed and enforced according to the laws of the State of Idaho to the extent not preempted by any federal law.

29. MODIFICATION OF BENEFITS

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirements or limitation on benefits imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by a Participant with or without the consent of such Participant.

Plan Year	Reimbursement Amount
July 1, 1997 – June 30, 1998	$5,000

STATE OF IDAHO
AMENDMENT TO SECTION 125 PLAN

WHEREAS, the Employer established the STATE OF IDAHO SECTION 125 PLAN;

WHEREAS, the Employer desires to amend its Section 125 Plan.

NOW, THEREFORE, the Employer amends its Section 125 Plan as follows, such amendments to be effective a of the first day of the Plan Year beginning after December 31, 2001:

1. Section 2.16 of the Section 125 Plan is amended to read as follows:

2.16 "Qualified Benefit" shall mean any benefit which is not includible in the gross income of the Employee by reason of an express provision of Chapter 1 of Subtitle A of the Code (other than Code Sections 106(b), 117, 127, or 132) and which is offered as a Benefit under this Plan.

2. Section 3.6 is added to read as follows:

3.6 Notwithstanding anything herein to the contrary, no Employee is required to complete more than three (3) years of employment with the Employer as a condition of participation in this Plan. Any Employee who has satisfied the employment requirement of the preceding sentence and who is otherwise entitled to participate in the Plan shall commence participation no later than the first day of the first Plan Year beginning after the date the employment requirement was satisfied unless the Employee was separated from service before the first day of that Plan Year.

3. Section 3.7 of the Section 125 Plan is added to read as follows:

3.7 If the Employer is subject to the FMLA and a Participant takes an unpaid leave of absence under the FMLA ("FMLA Leave"), such Participant may revoke his election to participate under any Qualified Benefit offered under this Plan for the period of FMLA Leave. Such revocation shall be effected in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave subject to any changes in benefit levels that may have taken place during the period of FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan.

4. Section 3.8 of the Section 125 Plan is added to read as follows:

3.8 A Participant who takes an FMLA Leave and who elects to continue participation under this Plan shall be responsible for making the required contributions for a Qualified Benefit

during the period of the FMLA Leave. The manner in which such payments are made shall be determined by the Plan Administrator in its sole discretion, among the following alternatives:

(a) Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayment may not be required as a condition to remaining in the Plan, and prepayment may not be the sole method of making contributions hereunder.

(b) Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

All payments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

5. Section 4.7 of the Section 125 Plan is amended to read as follows:

4.7 Elections made under the Plan (or deemed to be made under Section 4.5) shall be irrevocable by the Participant during the Plan Year, subject to the following:

(a) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan Administrator shall automatically increase or decrease, as the case may be, all affected participants' elections for such Benefit. Alternatively, if the cost charged to a Participant for a benefit package option (as defined in Treas. Reg. Section 1.125-4(i)) significantly increases or significantly decreases during a Plan Year, the Plan Administrator shall permit the affected Participants to make a corresponding change in election including commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage (as defined in treas. Reg. Section 1.125-4(i)(9)) or dropping coverage if no other benefit package option providing similar coverage is available.

A cost change is allowable in the Dependent Care Assistance Plan only if the cost change is imposed by a dependent care provider who is not related to the Participant (as defined in Code Section 152(a)(1) through (8)).

A Participant shall not be permitted to change an election to the Medical Reimbursement Plan as a result of a cost change under this subsection.

(b) Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the

remainder of such Plan Year if, under the facts and circumstances, a change in status occurs and the election change satisfies the consistency rule. For the purposes of this subsection, a change in status shall only include the following events or any other events permitted by Treasury Regulations:

(1) Legal Marital Status: Events that change a Participant's legal marital status, including the following: marriage, divorce, death of a spouse, legal separation and annulment;

(2) Number of Dependents: Events that change a Participant's number of dependents, including the following: birth, death, adoption and placement for adoption;

(3) Employment Status: Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; commencement of or return from an unpaid leave of absence; and change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the employer of the participant, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements: Events that cause the Participant's dependent to satisfy or cease to satisfy the eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance; and

(5) Residence: A change in the place of residence of the Participant, spouse or dependent.

(6) Dependent Care Assistance: If the Employer maintains a Dependent Care Assistance Plan, a dependent becoming or ceasing to be a qualifying individual (as defined under Code Section 21(b)) shall also qualify as a change in status.

An election change satisfies the requirements of this subsection with respect to accident or health coverage only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under the Plan. A change in status that affects eligibility under the Plan includes a change in status that results in an increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the Plan.

An election change satisfies the requirements of this subsection with respect to accident or health coverage only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under the Plan. An election change also satisfies the requirements of this subsection if the election change is on account of and corresponds with a change in status that affects expenses described in Code Sections 129 or 137.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such an event. In addition, if the Participant, spouse or dependent gains eligibility for coverage under a family member plan (as defined in Treas. Reg. Section 1.125-4(i)) as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Any new election shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator.

Notwithstanding anything herein to the contrary, a Participant may only increase Benefit elections under the Medical Reimbursement Plan in the event of a change in status.

(c) Notwithstanding the foregoing, a Participant may change an election for coverage under the Group Health Plan during a Plan year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) (relating to HIPAA).

(d) Notwithstanding the foregoing, in the event of a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical support order as defined in Section 609 of ERISA) that requires accident or health coverage for a Participant's child who is a dependent of the Participant:

(1) The Plan may change an election to provide coverage for the child if the Order requires coverage under the Participant's Plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the Order requires the spouse, former spouse or other

individual to provide coverage for such child and that coverage is, in fact, provided.

(e) Notwithstanding the foregoing, a Participant may make a prospective election to cancel or reduce accident or health coverage for the Participant of the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if a Participant, spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to commence or increase coverage of the Participant, spouse or dependent under the accident or health plan.

6. Section 4.8 of the Section 125 Plan is amended to read as follows:

4.8 Except as otherwise provided in this Plan, if a Participant terminates employment with the Employer and revokes (or is deemed to revoke) existing Benefit elections and terminates (or is deemed to terminate) the receipt of Benefits, and such Participant returns to work for the Employer during the Plan Year in which he terminated employment, such Participant shall not make any new Benefit elections for the remaining portion of the Plan Year. However, the reemployed Participant may receive Benefits under the Plan in accordance with the election which was in effect prior to his termination of employment with the Employer. Except as provided in Code Section 4980B (relating to COBRA), elections made under this Plan (or deemed to be made under Section 4.5) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or Benefits under the plans available under Section 4.1 may continue if and to the extent provided by such plans.

7. Section 7.12 is added to read as follows:

7.12 Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and the regulations thereunder.

8. Section 7.13 is added to read as follows:

7.13 Notwithstanding anything in this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

9. Exhibit B of the Section 125 Plan is amended to read as follows:

Plan Year	Reimbursement Amount
July 1, 2002 - June 30, 2003	$2,500

IN WITNESS WHEREOF, the Employer, by its duly authorized officer, has caused this Amendment to the above referenced Section 125 Plan to be adopted and this document executed this _____ day of _____, 2002.

Witnesses: STATE OF IDAHO

_____ By:_____

_____ Its:_____